

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7967

CERTIFICATE OF DEATH

07950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Grantsville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLYDELAND</u> Middle <u>EDGAR</u> Last <u>ASHBY</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	11. IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ser Station Operator & store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Button MD</u>	
11. BIRTHPLACE (State or foreign country) <u>Us. a.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Us. a.</u>	
13. FATHER'S NAME <u>John T. Ashby</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Schaeffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-03-7031</u>	
17. INFORMANT Address <u>Mrs Irva Mickey, Grantsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>5 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. p.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 6, 1958</u> to <u>July 13, 1959</u> , that I last saw the deceased alive on <u>July 12, 1959</u> , and that death occurred at <u>9:00 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Grantsville, Md.</u> DATE SIGNED <u>7/14/59</u> ACTUAL SIGNATURE <u>A. Paige Strong</u> PHYSICIAN'S NAME (Type) <u>A. Paige Strong</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville, Grantsville, Garrett Co., Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

7968

CERTIFICATE OF DEATH

Reg. Dist. No.

07951

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN 1b 50 yrs.		2. USUAL RESIDENCE (Where deceased lived. If instance of Residence before admission) a. STATE Maryland.		b. COUNTY Garrett	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				d. STREET ADDRESS 1 -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Myrtle		Middle Gower		Last Bittinger		4. DATE OF DEATH Month July Day 12, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27, 1893		9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Henry Gower				14. MOTHER'S MAIDEN NAME Julia Ann Lower					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		17. INFORMANT Address Ray E. Bittinger Mt. Lake Park, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Heart Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 1 year 5 years 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/12/ 19 40 , to 7/12/ 19 59 , that I last saw the deceased alive on 7/11/59 , 19 59 , and that death occurred at 2:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 13 July 59									
ACTUAL SIGNATURE Andrew E. Mance M.D.		PHYSICIAN'S NAME (Type) Andrew E. Mance, M.D. Oakland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/1959		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE JUL 22 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07952

Reg. Dist. No.

7969

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>8 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Polyard</u> Last <u>Polyard</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1877</u>
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John M. Polyard</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hershman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Nora Polyard, Box #117, Crellin, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident, left</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain - Pneumonia</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>2 1/2 hrs</u> <u>7 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 58</u> , 19 <u>59</u> , to <u>7-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-2</u> , 19 <u>59</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James H. Feaster, Jr. M.D. 582-1st Oakland, Md. 7-3-59</u>			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D. <u>582-1st Oakland, Md.</u> 7-3-59			
PHYSICIAN'S NAME (Type) <u>James H. Feaster, Jr. M.D. Oakland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/6/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Israel Cemetery</u>	22d. LOCATION (City, town, county, state) <u>near Fellowsville, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

MASSACHUSETTS

Blank form with horizontal lines for text entry.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 07953									
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 40, Long Stretch, F'bg.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avilton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First BONNIE Middle LEE Last BROADWATER					4. DATE OF DEATH Month 7 Day 13 Year 19 59				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15th, 1951		9. AGE (in years last birthday) 8 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roy Broadwater					14. MOTHER'S MAIDEN NAME Diona Crowe				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Roy Broadwater, Avilton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured SKULL 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Broken neck DUE TO (c) 777014 P/E Contusions								INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by automobile when crossing road, Rt. 40 6 mi. west of Frostburg, Maryland						
20c. TIME OF INJURY Month, Day, Year Hour 4 a.m. 713 p.m. 19 59			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 40 Street		20f. (City or town) (County) (State) Frostburg Garrett Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John W. Foster					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) J H Foster, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 7-16-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.					24a. REC'D BY REGISTRAR JUL 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank		

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-19-23

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HYG. 10-1-1923

Deceased

Residence

Occupation

Age

Sex

Date of Death

Time of Death

Place of Death

For Reporting

By Doctor

For Reporting (If Not)

Signature of Doctor

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

Signature of Clerk

Signature of Nurse

Signature of Undertaker

Signature of Burial

Signature of Cremation

Signature of Other

Signature of Witness

Signature of Juror

Signature of Judge

Signature of Jury

Signature of Court

Signature of State

Signature of Federal

Signature of Local

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7971

CERTIFICATE OF DEATH

Reg. Dist. No.

07954

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural Deer Park	
c. LENGTH OF STAY IN 1b 25 yrs.		d. STREET ADDRESS R. D. 1 mi. West	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. one mile west Deer Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Hugh Last Campbell		4. DATE OF DEATH Month July Day 27 , Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Track worker,		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Campbell		14. MOTHER'S MAIDEN NAME Malinda Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-01-8804	
17. INFORMANT Mrs. Dora Campbell		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cumy Acid Poison DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchial asthma			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1956 to July 27, 1959 , that I last saw the deceased alive on July 27, 1959 , and that death occurred at 5:00 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph Calandrella		DATE SIGNED July 31-59	
PHYSICIAN'S NAME (Type) Ralph Calandrella, M.D.		Kitzmailler, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/30/1959	22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery	22d. LOCATION (City, town, or county) (State) Deer Park, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR AUG 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BOND

DOE IN A CAR

WILLIAM BOND

STATE AND DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7972

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07955

1. PLACE OF DEATH a. COUNTY <u>Garrett</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accident R.D.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accident R.D.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DIANA</u> Middle <u>ELAINE</u> Last <u>DURST</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1956</u>		9. AGE (In years last birthday) <u>2</u> yrs.	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edison Durst</u>				14. MOTHER'S MAIDEN NAME <u>Lula Pittinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Lula Durst, Accident, R.d. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRAUMA SKULL</u> 82 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran over by car</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7:23</u> p.m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Garrett</u>		20f. (City or town) (County) (State) <u>Garrett Co., Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. Feaster</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. Feaster</u>				DATE SIGNED <u>7-23</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 25, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don G. Newman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief of Medical Examiner's Office along with Form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used on a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7973

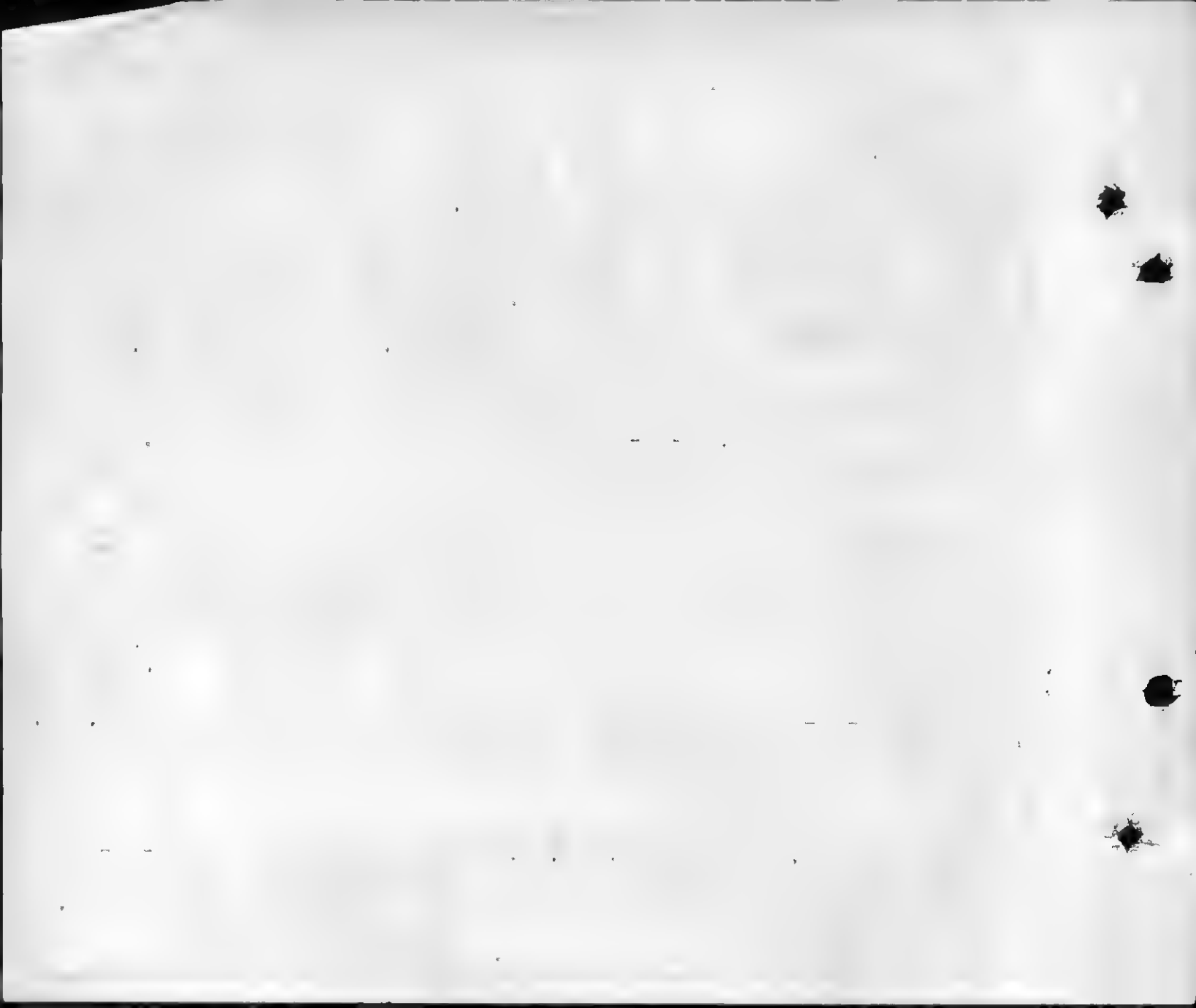
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07956

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Accident				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Working in woods So. Accident				e. STREET ADDRESS 2 Mi. S.E. Deer Park			
3. NAME OF DECEASED (Type or print) First Lawrence Middle Clifton Last Ervin				4. DATE OF DEATH Month July Day 21 , Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1918		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, cutting trees in woods		10b. KIND OF BUSINESS OR INDUSTRY Maryland.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Coy Webster Ervin				14. MOTHER'S MAIDEN NAME Bessie Paugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-01-8605		17. INFORMANT Victor Ervin		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 910.1 (c) 							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While cutting a tree down, another tree fell and struck pt. on head,					
20c. TIME OF INJURY Month, Day, Year 12:45 p.m. 7-21-1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Rural Accident Garr. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-21-59	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/1959		22c. NAME OF CEMETERY OR CREMATORY Paugh Cemetery		22d. LOCATION (City, town, or county) (State) 2 Mi. S.E. Deer Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Lighton</i>				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JUL 27 59	
						24b. REGISTRAR'S SIGNATURE <i>Robert S. Hanna</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the words "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To the funeral director: File pages 1 and 2 with the registrar for burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7974

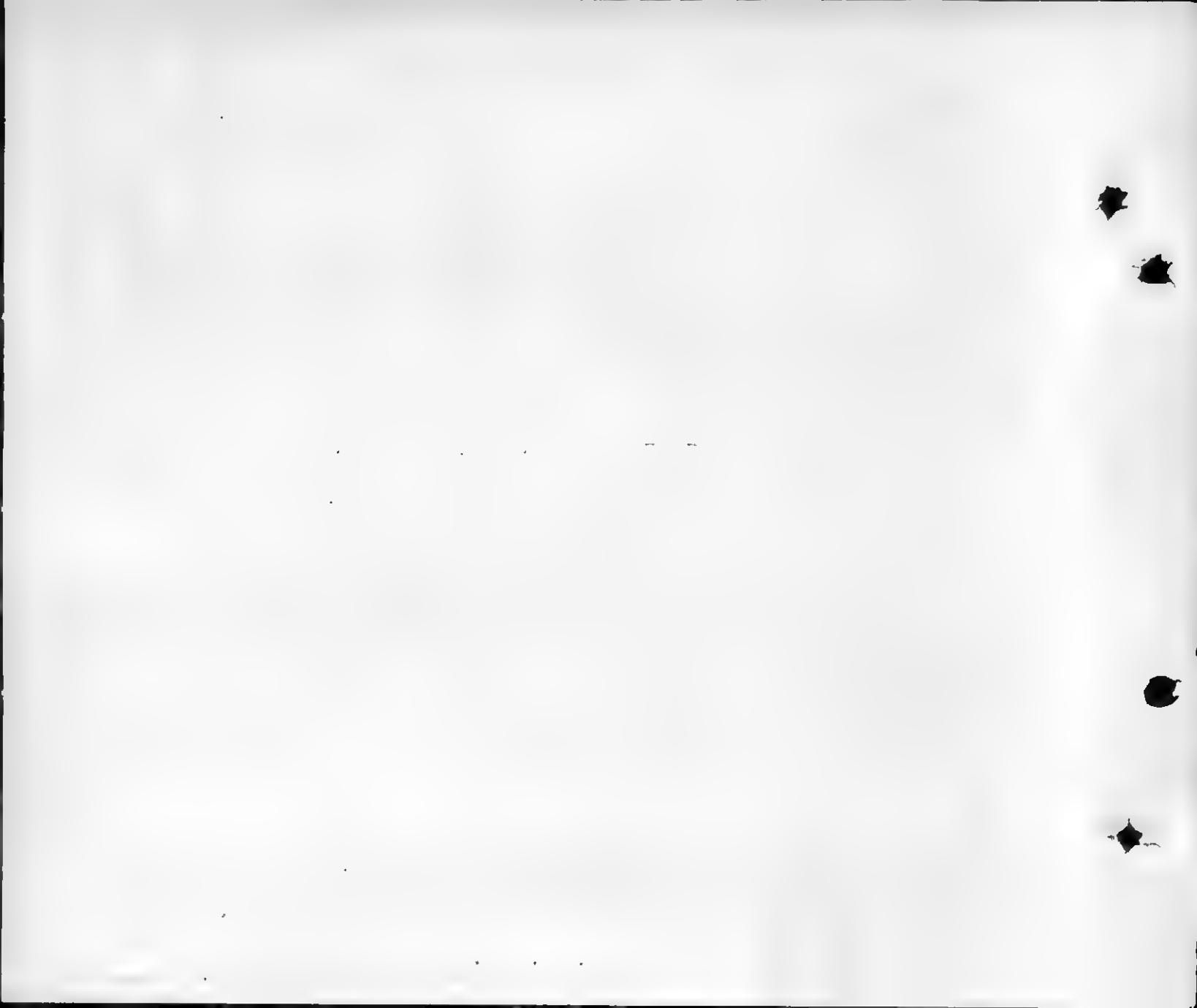
CERTIFICATE OF DEATH

07957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's County Memorial Hospital</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Wiley</u>		4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	9. AGE (In years last birthday) yrs <u>58</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
11. BIRTHPLACE (State or foreign country) <u>United States</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Wiley</u>		14. MOTHER'S MAIDEN NAME <u>Annie Neekin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>		16. SOCIAL SECURITY NO <u>213-12-9250</u>	
17. INFORMANT <u>John Wiley</u>		Address <u>1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial heart disease & hypertrophy</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 9, 1945</u> to <u>July 10, 1959</u> , that I last saw the deceased alive on <u>July 10, 1959</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. S. Mance</u> M.D.		ADDRESS (Street, city or town, state) <u>Oakland Md</u> DATE SIGNED <u>11/July/59</u>	
PHYSICIAN'S NAME (Type) <u>R. S. Mance</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/13/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oakland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	24a. REC'D BY REGISTRAR <u>SUL 1 4 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Mance</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7975

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 6 1/2 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kitzmiller			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				d. STREET ADDRESS 4 Mi. N. Kitzmiller		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Stanley Middle Harvey Last Harvey				4. DATE OF DEATH Month July Day 14, Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1909	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during or working life, even if retired) Laborer & School Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Harvey				14. MOTHER'S MAIDEN NAME Birdie Blanche Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-2952		17. INFORMANT Address Mrs. Arvella Harvey R.D. Kitzmiller, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemopericardium 451X DUE TO Conditions, if any, which gave rise to immediate cause (b) Ruptured Dissecting aneurysm of aorta (c) DUE TO (a) (b) (c) 							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				7-15-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/1959		22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JUL 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. No burial, cremation, or removal of the remains should be made until the certificate is received. File pages 1 and 2 with the registrar permit. File pages 3 and 4 with the registrar permit.

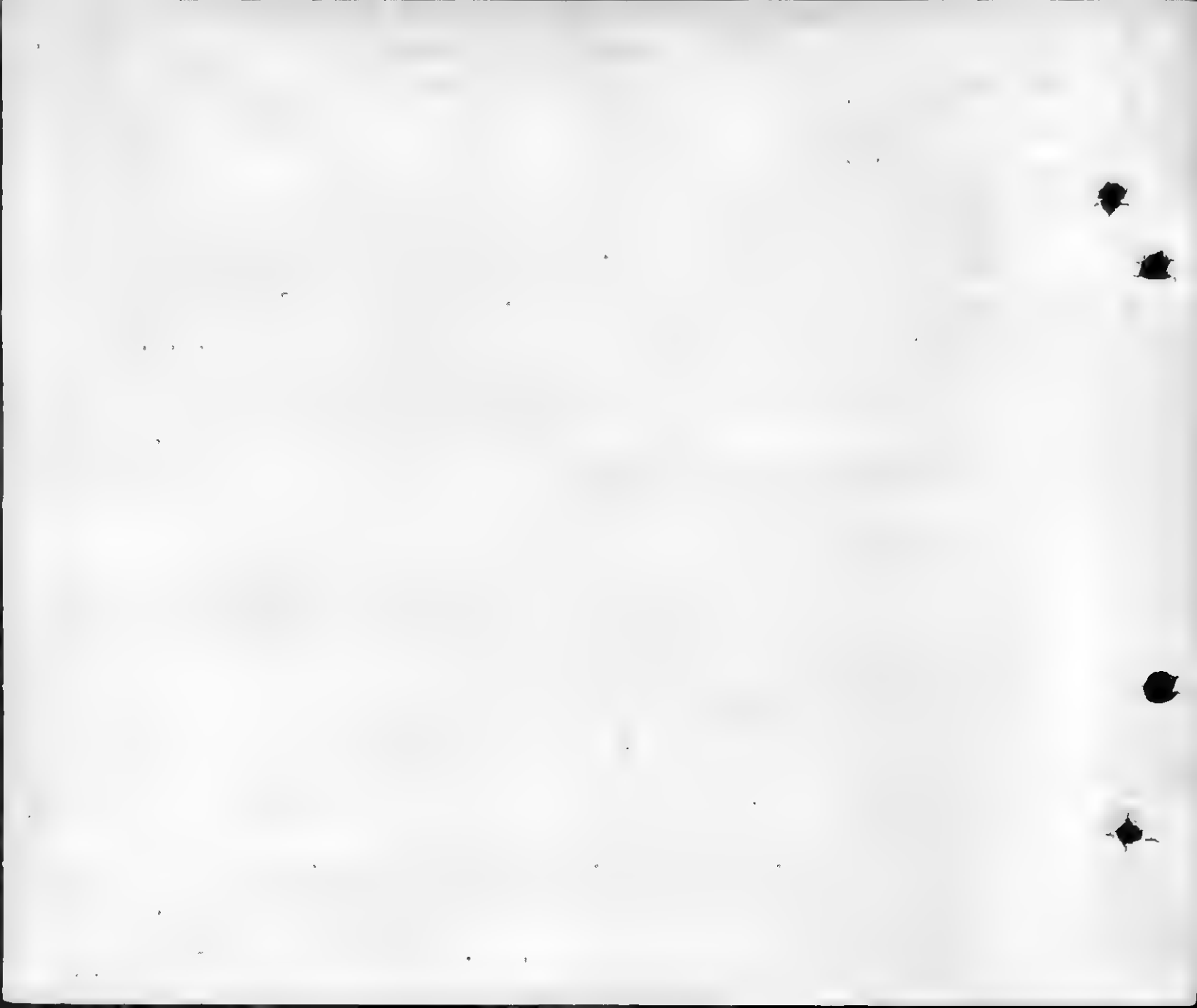


07959

Reg. Dist. No.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppertt Nursing Home		e. IS RES DENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS Sang Run Road					
3. NAME OF DECEASED (Type or print)		First Thomas		Middle H.		Last Hawkins		4. DATE OF DEATH Month July Day 2, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1878		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 01 Days 01 Hours 01 Min 01		IF UNDER 24 HRS Months 01 Days 01 Hours 01 Min 01
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Marion Hawkins				14. MOTHER'S MAIDEN NAME Mary Eddy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Eldie Piggot		Address Enterprise, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphatic Leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April , 19 59 , to June , 19 59 , that I last saw the deceased alive on June 25 , 19 59 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE Herbert H. Leighton		M.D.		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md.		DATE SIGNED 7/3/59			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D. Oakland, Md.									
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/1959		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		22d. LOCATION (City, town, or county) (State) near McHenry, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JUL 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7977

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07960

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD Lonaconing, Md.</u>		c. LENGTH OF STAY IN 1b <u>19 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD Lonaconing, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>LIZBETH</u> Last <u>HETZ</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 23, 1870</u>		9. AGE (In years last birthday) <u>89</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson Wilhelm</u>				14. MOTHER'S MAIDEN NAME <u>Allen Marie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Thomas Hetz, RFD, Lonaconing, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Newman</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James H. Newman</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's</u>		22d. LOCATION (City, town, or county) (State) <u>Milton, Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur H. ...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7978

CERTIFICATE OF DEATH

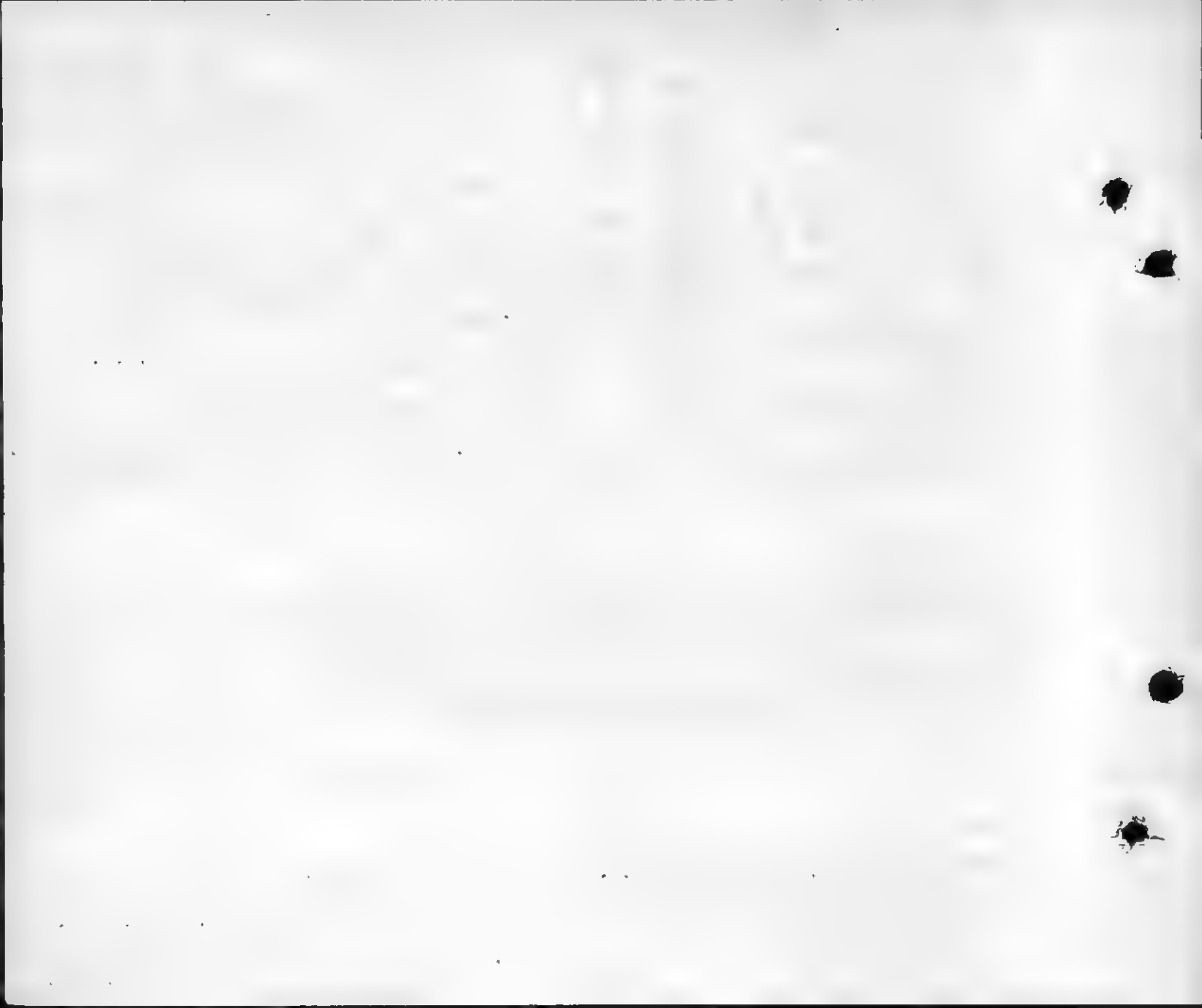
Reg. Dist. No.

07961

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN IT 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JULIA Middle MC HENRY Last HOWARD				4. DATE OF DEATH Month JULY Day 10 Year 19 59			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 29, 1886		9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher, in Baltimore				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles MC HENRY HOWARD			
14. MOTHER'S MAIDEN NAME JULIA ANNA COLEMAN				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT HELEN J. SHOLLY Address 79 ALDER STREET, OAKLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL (arteriosclerotic) hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) HYPERTENSION							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-7 19 59 , to 7-10 19 59 , that I last saw the deceased alive on 7-10 19 59 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE James H. Feaster, Jr. M.D. 2821 14th Avenue, Baltimore, Md.				PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR. M.D. OAKLAND, MARYLAND			
22a. BURIAL CREMATION, REMOVAL (Specify) REMOVED		22b. DATE THEREOF 7/11/1959		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery, 4906 North Howard, Baltimore, Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE JUL 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7979

CERTIFICATE OF DEATH

Reg. Dist. No. 07962

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE ESTELLA HUMBERSON		4. DATE OF DEATH Month JULY Day 27 Year 1959	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 57 yrs IF UNDER 1 YEAR: Months 7 Days 10 Hours 15 Min 00
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK J. HUMBERSON		14. MOTHER'S MAIDEN NAME ELIZABETH J. HUMBERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO ----	
17. INFORMANT EVAN J. HUMBERSON		Address 1000 E. FRIENDSVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Standstill 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Anteroseptal Myocardial Infarct DUE TO (c) Coronary Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-10-1959 to 7-28-1959 that I last saw the deceased alive on 7-26-59 , 1959 , and that death occurred at 10:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ledy Rivera		ADDRESS (Street, city or town, state) Friendsville, Md. DATE SIGNED 7/28/59	
PHYSICIAN'S NAME (Type) DEDEO RIVERA, M.D.		FRIENDSVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/29/1959	22c. NAME OF CEMETERY OR CREMATORY Humberston Cemetery near Friendsville, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE JUL 31 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7980

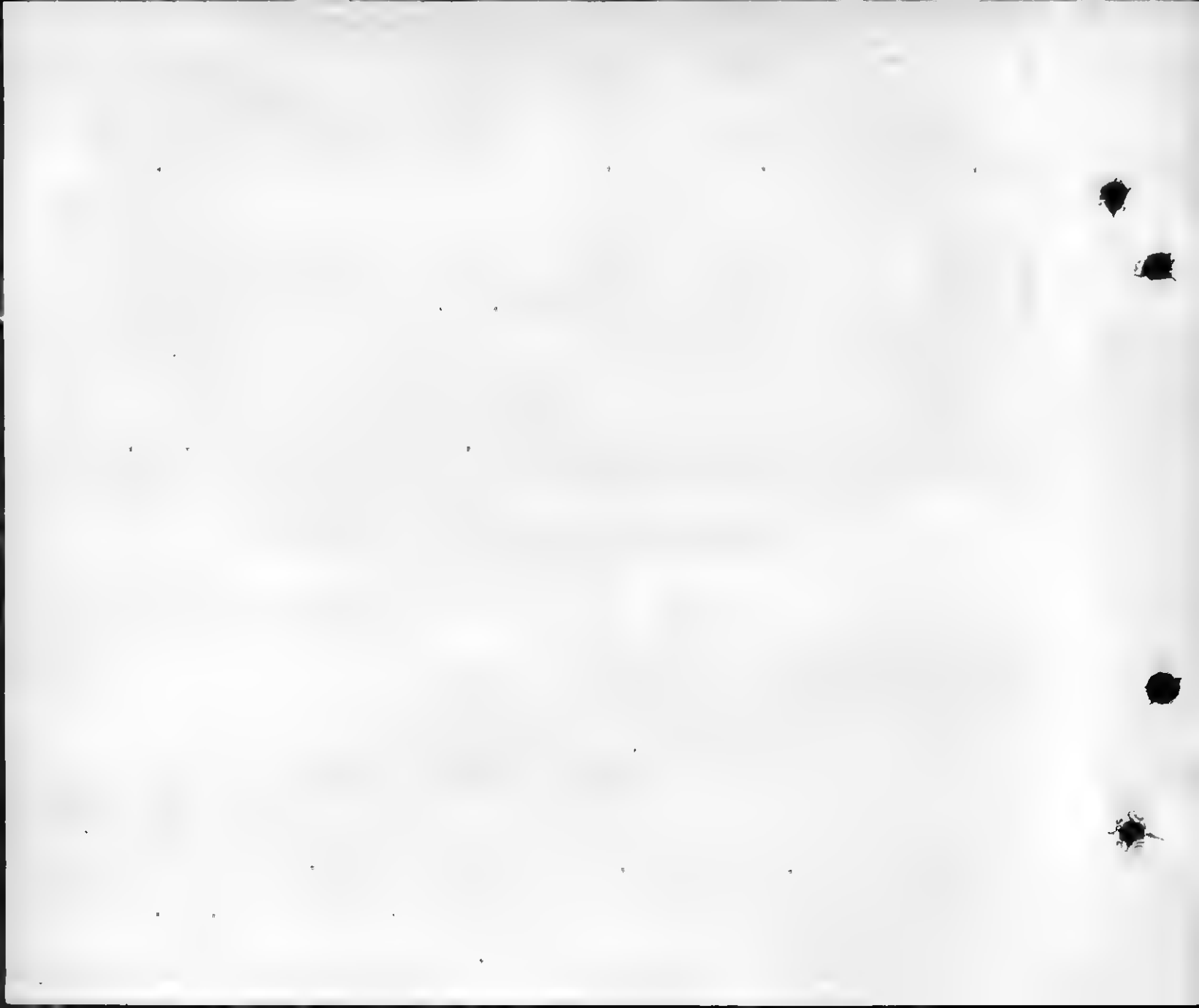
CERTIFICATE OF DEATH

Reg. Dist. No.

07963

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Bayard, W. Va.		c. LENGTH OF STAY IN 1b 22 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION across the river from Bayard, W. Va.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Kelley		4. DATE OF DEATH Month July Day 4 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1886
9. AGE (In years last birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Maust		14. MOTHER'S MAIDEN NAME Minnie Jamison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hilary E. Kelley		Address Bayard, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Hypertrophy of failure DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Arteriosclerosis DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 82 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 Jan., 1959 to 30 June, 1959 , that I last saw the deceased alive on 30 June, 1959 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED July 5, 1959	
PHYSICIAN'S NAME (Type) Andrew E. Mance, M.D.		Oakland, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/7/1959	22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	22d. LOCATION (City, town, or county) (State) near - Gorman, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE JUL 9 '59
		24b. REGISTRAR'S SIGNATURE Andrew E. Mance	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7981

CERTIFICATE OF DEATH

07964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>9 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Evans Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Stretton</u>			
f. STREET ADDRESS <u>Evans Nursing Home</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lavenia</u> <u>Agnes</u> <u>Kreip</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1955</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 12, 1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Hill</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. <u>174X</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary atherosclerosis with generalized</u> DUE TO (c) <u>retention</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>July 2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>55</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Ralph Calandrella</u> M.D. <u>Kitz Miller, Md</u> <u>July 6-55</u> PHYSICIAN'S NAME (Type) <u>Ralph CALANDRELLA</u> <u>Kitz Miller</u> <u>Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/6/1 55</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halper Funeral Home</u>				ADDRESS <u>23 East Main Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7982

CERTIFICATE OF DEATH

Reg. Dist. No. 07965

1 PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EVANS NURSING HOME		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROWLESBURG d. STREET ADDRESS MAIN STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALLEN Middle A. Last MAY		4. DATE OF DEATH Month JULY Day 7th Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 23, 1868
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 3 Days 14	11. IF UNDER 24 HRS Hours 1 Min 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED OFFICE CLERK		10b. KIND OF BUSINESS OR INDUSTRY B & O R R Co	
11 BIRTHPLACE (State or foreign country) ROWLESBURG WEST VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS MAY		14. MOTHER'S MAIDEN NAME MALISSA ROGERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 236-40-9489	
17. INFORMANT Mrs. Mrs. Martha Eliason, Rowlesburg, W.Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis with myocardial infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Pneumonia, Right Lower Lobe. Arteriosclerosis Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 5 days 5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1959 to July 7, 1959 that I last saw the deceased alive on July 5th, 1959 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Aurora, W. Va. DATE SIGNED 7-8-59			
ACTUAL SIGNATURE Alfred Owre, Jr. M.D.		PHYSICIAN'S NAME (Type) ALFRED OWRE, M.D.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/59	
22c. NAME OF CEMETERY OR CREMATORY AURORA CEMETERY		22d. LOCATION (City, town, or county) (State) AURORA WEST VIRGINIA.	
23. FUNERAL DIRECTOR'S SIGNATURE P.R. Watson ADDRESS TERRA ALTA W. VA.		24a. REC'D BY REGISTRAR DATE JUL 10 '59	
24b. REGISTRAR'S SIGNATURE William E. Harts			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7983

CERTIFICATE OF DEATH

Reg. Dist. No.

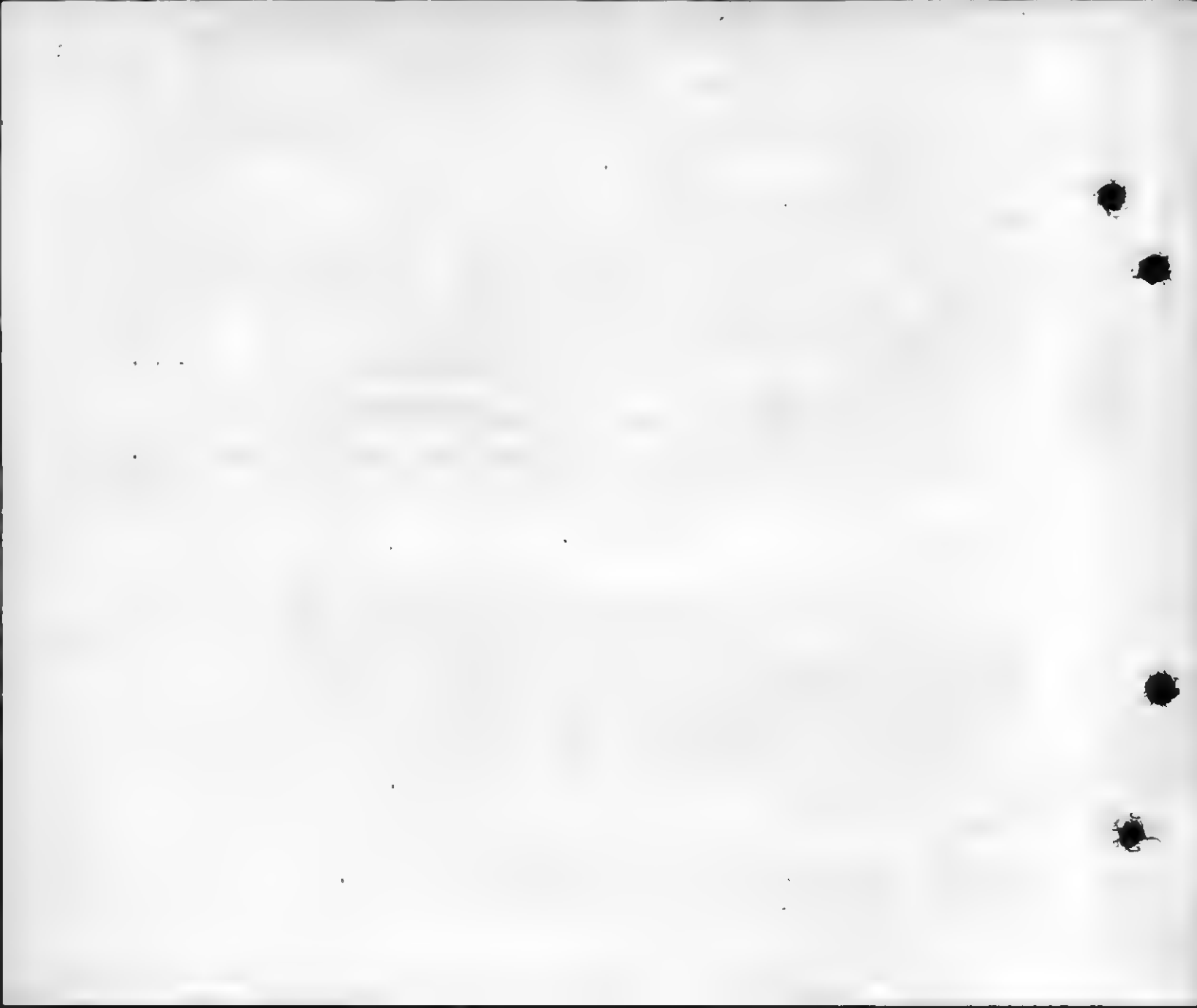
07966

1. PLACE OF DEATH a. COUNTY <u>Jeffett</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Jeffett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Accident</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Accident</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BOICHOV</u> Middle <u>CLAY</u> Last <u>P</u>		4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Bittint r, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Orendorf</u>		14. MOTHER'S MAIDEN NAME <u>Polly Hochsteitler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hugh Orendorf, R.R.D. Accident, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u> </u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 20, 1959</u> to <u>July 4, 1959</u> that I last saw the deceased alive on <u>July 3, 1959</u> , and that death occurred at <u>12:04 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph Calandrelli</u>		ADDRESS (Street, city or town, state) <u>Kitzmiller, Md</u> DATE SIGNED <u>July 6-59</u>	
PHYSICIAN'S NAME (Type) <u>RALPH CALANDRELLI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Glade</u>	22d. LOCATION (City, town, or county) (State) <u>Jeffett, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 59</u>	
ADDRESS <u>Grantsville, Md/</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7985

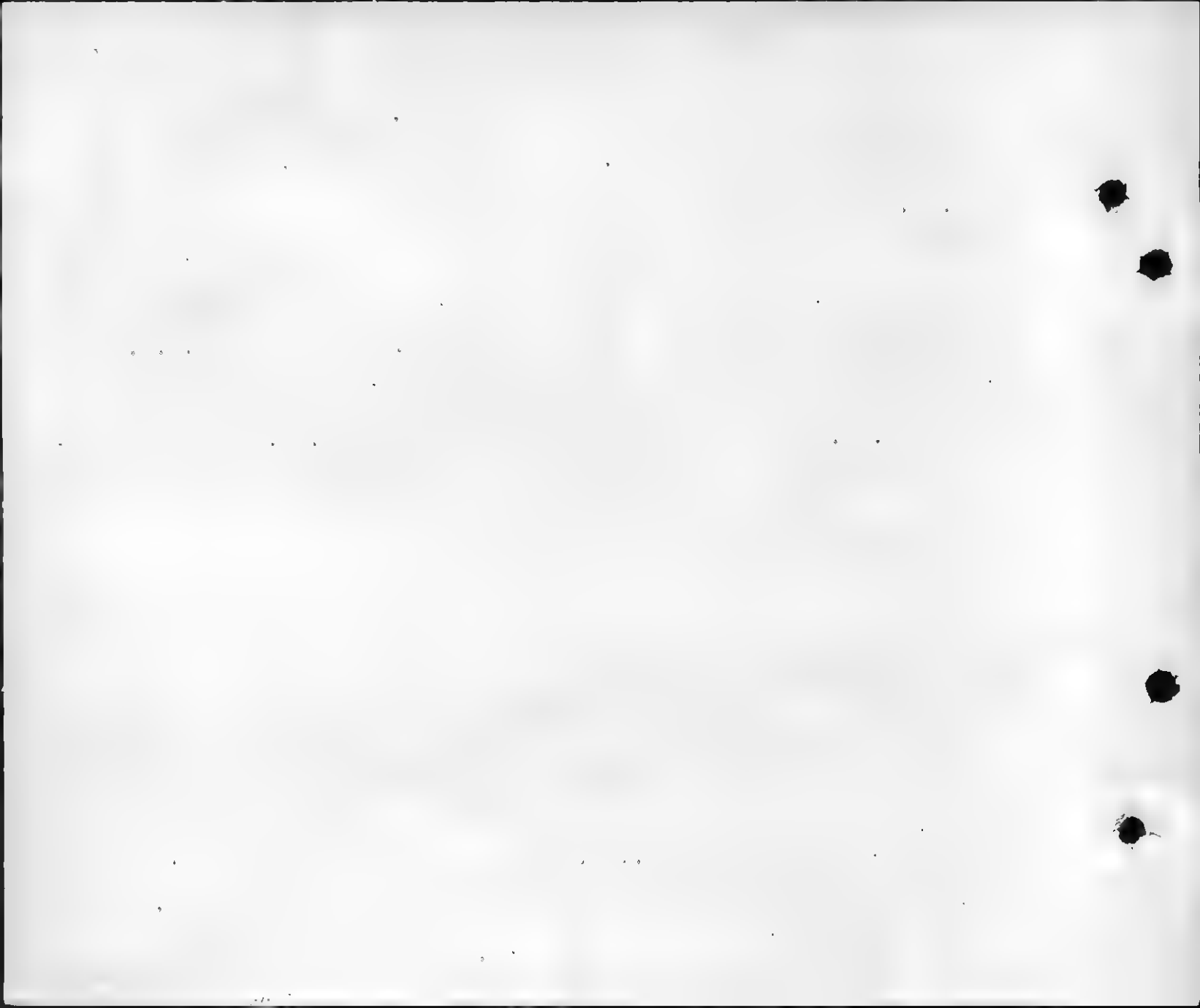
CERTIFICATE OF DEATH

Reg. Dist. No.

07968

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park, c. LENGTH OF STAY IN 1b 20 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Mi. N. Deer Park, Rt. 219		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Deer Park, d. STREET ADDRESS Route #219 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rex Middle Snyder Last Snyder		4. DATE OF DEATH Month July Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1908
9. AGE (In years last birthday) 51 yrs		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Maryland.	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Snyder		14. MOTHER'S MAIDEN NAME Amanda Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W. W. #2	
17. INFORMANT Mrs. Rex Snyder		Address R. D. Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Chronic Kidney Disease INTERVAL BETWEEN ONSET AND DEATH 7 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Kidney Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-1 , 19 58 , to 7-2 , 19 59 , that I last saw the deceased alive on 7-2 , 19 59 , and that death occurred at 7:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James H. Feaster Jr. M.D. Oakland, Maryland. PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D. Oakland, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/5/1959	22c. NAME OF CEMETERY OR CREMATORY Ferndale Cemetery	22d. LOCATION (City, town, or county) near Oakland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Reighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE JUL 9 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Thrall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7986 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07969

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 135 to Cumberland,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mountain Lake Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On route to Baltimore, Md.</u>				e. STREET ADDRESS - - - -		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ronald</u> Middle <u>Ernest</u> Last <u>Tasker</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> , Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>May 15, 1941</u>		9. AGE (In years last birthday) <u>18</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest G. Tasker</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-38-1787</u>		17. INFORMANT Address <u>Mrs. Nellie Tasker Mt. Lake Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, BILATERAL, FULMINATING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, JR., M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>7-2-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Deer Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. E. Leighton</u> ADDRESS <u>Oakland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files. To burial, cremation, or removal, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

U.S. STATE DEPARTMENT OF STATE

07970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb 13 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE #1, BOX #30 S		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MILTON EDWARD TUCKER		First Middle Last		4. DATE OF DEATH JULY 15 1959		Month Day Year	
5. SEX male		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 10, 1894	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Own Farm FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DAVID TUCKER		14. MOTHER'S MAIDEN NAME LAURA RILEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-03-9257		17. INFORMANT JANE TUCKER, ROUTE #1, BOX #30 S DEER PARK, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-Phrenic Abscess with massive Right Pleural Effusion DUE TO Advanced Metastatic Carcinoma DUE TO Carcinoma of the Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6 Month 12-18 Months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Nephrectomy - Renal Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1959 , to July 15, 1959 , that I last saw the deceased alive on July 15, 1959 , and that death occurred at 11:25 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 27 Oak Street, Oakland, Md.		DATE SIGNED July 16, 1959			
ACTUAL SIGNATURE Herbert H. Leighton		M.D.					
PHYSICIAN'S NAME (Type) HERBERT LEIGHTON, M.D.		OAKLAND, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/18/1959		22c. NAME OF CEMETERY OR CREMATORY White Church Cemetery		22d. LOCATION (City, town, or county) (State) 6 Mi. S. Deer Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JUL 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1911

MASSACHUSETTS
STATE DEPARTMENT OF HEALTH
BOSTON

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

